Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: SURGERY SPECIALTY HOSPITALS OF AMERICA SE HOUSTON CAMPUS 4301 VISTA ROAD PASADENA TX 77504	MFDR Tracking #: M4-09-A975-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ILLINOIS NATIONAL INSURANCE CO. Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…With regard to the charges at issue in this dispute, there is no evidence presented by the Carrier that the prices billed were not Provider's usual and customary charges (which the Provider must bill under Division rules) or that the final price was not fair and reasonable. Therefore, the Carrier is required to reimburse Surgery Specialty Hospitals of American S.E. $25,731.72 pursuant to the Outpatient Fee Guidelines, which will result in fair and reasonable reimbursement for the services provided to the injured worker. The Carrier made a partial payment of $17,884.13. Therefore, the Carrier is required to reimburse Provider in the additional amount of $7,847,59, plus any and all applicable interest…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill
3. EOBs
4. Medical Reports
5. Total Amount Sought $7,847.59

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…This date of service was paid based upon the medicare [sic] reimbursement plus the percentage increase specific to this case and pursuant to the current multiple procedural rule. Therefore, the Provider has been correctly paid and is owed no additional reimbursement…"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
08/01/2008	Outpatient Hospital Services Revenue Codes 250, 270, 272, 370, 420, 460, 480, 710, and 762 CPT Codes 94760 x 2 And 99205	N/A	$7,847.59	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 11/05/2008 listed the following reduction/denial codes. The reduction/denial codes were not separately listed on the disputed Revenue or CPT Codes but listed on the last page of the explanation of benefits:
   - OMB – Outlier payment has been proportional distributed to all covered OPPS services;
   - 4Y8 – Workers Compensation State Fee Schedule adjustment;
   - 06Q – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed;
   - 4UV – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated;
   - 0Q6, 807 – Documentation does not support billed charge, no recommendation of payment can be made;
   - 45M – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate;
   - O4P – Reimbursement based on Outpatient/Inpatient rate; and
   - OM4 – Service not paid under Medicare OPPS.

   Explanation of benefits with the listed date of audit of 07/22/2009 listed the following reduction/denial codes:
   - ORH – Original payment decision is being maintained. This claim was processed properly the first time;
   - 4Y8 – Workers Compensation State Fee Schedule Adjustment;
   - O6Q – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed;
   - 4UV – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated; and
   - 1JR – Additional payment made on appeal/reconsideration.

2. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"

3. Pursuant to Rule §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and

supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:

   (1) No contract exists;

   (2) MAR can be established for these services; and

   (3) Separate reimbursement for implantables was *NOT* requested by the requestor.

6. Revenue Codes 0250 (HCPCS Code J3490 listed on the UB-04); 0270 (HCPCS Code J4649 listed on the UB-04); 0272 (HCPCS Code A4649 listed on the UB-04); 0370 (CPT Code 99144 listed on the UB-04); and 0460 (CPT Code 94760 x 2 listed on the UB-04) are considered Status N codes. Status N codes are defined as services or procedures included in the APC rate, but not paid separately as they are packaged items.
7. Revenue Code 0420 (CPT Code 99071 listed on the UB-04) is considered a Status B code. Status B codes are not recognized by OPPS on Bill Type 12X, 13X or 14X; an alternate CPT/HCPCS code may be available.
8. Revenue Code 0480 (HCPC Code A9300 listed on the UB-04) is considered a Status E code. Status E codes are considered not-covered (or unused) codes and are not reimbursed.
9. Revenue Code 0710 (CPT Code 99205 listed on the UB-04) is considered a Status Q Code. The status code definition for this code is "This line was not fully/correctly grouped, and the claim should be repriced after the reason is identified."
10. Revenue Code 0762 (Observation – 23 hours) – In accordance with 28 Texas Admin. Code Section §134.403(d) coding, billing, reporting, and reimbursement of health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided. According to the OPPS manual observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are billed as follows: Revenue Code: 0762 is used as well as HCPCS code G0378, hospital observation services, per hour. The UB-04 submitted by the Requestor does not contain HCPCS Code G0378; in addition, no procedure with status indicator T can be reported on the same day or on the day before observation care is provided. According to the UB-04, Status T CPT Code 63075 was performed on the same day as the observation.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.305
28 TAC Rule §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute.

		July 6, 2010
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.